# Authorization to Release / Disclose Protected Health Information

**Steve Truman DDS Inc (D Street Dental)** · Patient authorization to use or disclose protected health information (PHI).

> **Production note (do not print on the patient copy):** Before this form is used, whoever generates the final PDF MUST set the entire authorization body — including Sections 5 (sensitive opt-ins) and 8 (signature) — in a typeface no smaller than **14-point**, to satisfy California Civil Code §56.11. Verify the rendered artifact actually measures 14-point or larger before distribution. If it does not, the CMIA recital in Section 8 is affirmatively false and the form must not be used.

---

**Use this form when:** you want us to send or receive your dental records, or to share your information with another provider, a family member, an attorney, an insurer, or anyone else you name. Please print clearly. If a blank does not apply to you, write "N/A."

**Practice (the party authorized to make this disclosure):** Steve Truman DDS Inc (D Street Dental) 1099 D Street, San Rafael, CA 94901 Phone: (510) 883-3011 Fax: —

---

## 1. Patient Information

| | |
|---|---|
| Patient full name (print): | _____ |
| Date of birth: | __ / _ / _ |
| Address: | _____ |
| Phone: | ___ Email: _____ |
| Patient record / chart #: | _____ (office use) |

---

## 2. Who May Receive My Information

I authorize **Steve Truman DDS Inc (D Street Dental)** to release/disclose the information described below **to** the following person or organization:

| | |
|---|---|
| Name of person/entity to receive the information: | _____ |

| | |
|---|---|
| Relationship to me (if a person): | _____ |
| Address: | _____ |
| Phone: | ___ Fax / Email: ___ |

> If you want us to **receive** records **from** another provider into your chart, also name that provider here: _____ (We will send them a copy of this signed authorization as your request to release your records to us.)

---

## 3. What Information I Am Releasing (specific and meaningful description)

Check every item you want released. This is a specific, meaningful description of the information to be used or disclosed.

- [ ] **Complete dental record** (clinical notes, exams, diagnoses, treatment history)
- [ ] **X-rays / images** (radiographs, photos, scans, CBCT)
- [ ] **Treatment plan** (proposed and completed treatment)
- [ ] **Billing / financial records** (statements, payments, insurance claims)
- [ ] **Only records from this date range:** from __ **/** _ **/** ***to*** **/ /** ___
- [ ] **Other (describe specifically):** _____

> **Note on sensitive records:** The categories above do **not** by themselves release the specially protected information listed in Section 5 (HIV/AIDS results, mental health information, or substance-use-disorder treatment records). To release any of those, you must also complete the matching opt-in in Section 5. This authorization also does **not** cover psychotherapy notes — see Section 5.

---

## 4. Purpose of This Disclosure (describe each purpose)

- [ ] **At my own request** ("at the request of the individual" — no further explanation required)
- [ ] Continued or new treatment / referral to another provider
- [ ] Insurance, benefits, or claims
- [ ] Legal matter / my attorney
- [ ] Share with a family member or other person I trust
- [ ] **Other (describe):** _____

---

## 5. Sensitive Information — Separate Opt-In Required

Some information has extra legal protection. We will **NOT** release any of the categories below unless you specifically opt in here by checking the box **and** writing your initials. Leaving a box blank means that type of information will **not** be released. Each opt-in below releases that information **only to the recipient you named in Section 2.**

**HIV / AIDS test results** (California Health & Safety Code §120980)

- [ ] I authorize release of my HIV/AIDS test results **specifically to the person or organization named in Section 2.** I understand my HIV/AIDS results will be disclosed to that named recipient. Patient initials: _____

**Mental health information** (does **not** include psychotherapy notes — see below)

- [ ] I authorize release of my mental health information and records **specifically to the recipient named in Section 2.** I understand this does **not** authorize release of psychotherapy notes. Patient initials: _____

> **Psychotherapy notes are NOT covered by this form.** Under federal law (45 CFR §164.508 and the definition at 45 CFR §164.501), psychotherapy notes — a mental-health professional's notes analyzing or documenting a private counseling session, kept separate from the rest of the record — require their **own separate, standalone authorization** and cannot be released using this form. This authorization does **not** release psychotherapy notes. If you want those released, ask us for a separate psychotherapy-notes authorization.

**Substance-use-disorder (alcohol/drug) treatment records** (federal law, 42 CFR Part 2)

- [ ] I authorize release of substance-use-disorder treatment records protected by 42 CFR Part 2 **specifically to the recipient named in Section 2.** Patient initials: __ **Name of the Part 2 program that created these records (if not this practice):** _____ ***Specific purpose of this substance-use-disorder disclosure (required — e.g., "for my treatment," "for payment," or another stated reason):*** _____

> **Does D Street Dental even hold Part 2 records?** A general dental practice typically does **not** create or maintain substance-use-disorder treatment records covered by 42 CFR Part 2. If the practice does not hold any such records, this substance-use-disorder opt-in does not apply and may be left blank. **Counsel should confirm whether to retain this section at all.**
>
> **Required notice for substance-use-disorder records (42 CFR Part 2):** This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal

> rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

---

## 6. Expiration

This authorization expires on the earliest of the following:

- [ ] **Date:** __ / _ / _
- [ ] **Event:** _____ (Use a clear, definite event — for example, "when my records have been received by the new provider," or "60 days after my legal matter is closed." Vague events that have no clear end date may not be enforceable.)

> **If you leave both the date and the event blank, this authorization automatically expires ONE (1) YEAR from the date you sign it.**

*(California requires that an authorization have an expiration. One year is this practice's default policy choice, not a legal minimum — counsel may set a different default.)*

---

## 7. My Rights — Please Read Before Signing

**Right to revoke.** I may cancel (revoke) this authorization at any time. To do so, I must put my request **in writing** and send or deliver it to: **Dr. Steve Truman**, Steve Truman DDS Inc (D Street Dental), 1099 D Street, San Rafael, CA 94901. My revocation takes effect when the practice receives it. **Exceptions:** (1) revoking will not undo any action the practice already took while relying on this authorization before it received my written revocation; and (2) revocation does **not** reach information that has already been disclosed — once information has left the practice, it cannot be retrieved. The sensitive-category records in Section 5 may carry their own separate revocation and re-disclosure rules under state and federal law (for example, substance-use-disorder records under 42 CFR Part 2).

**No conditioning of treatment.** The practice **will not** condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.

**Possible re-disclosure.** Information disclosed under this authorization may be **re-disclosed by the person or organization that receives it** and, if so, may **no longer be protected** by federal HIPAA privacy rules. (Some information — such as the sensitive categories in Section 5 — may carry additional re-disclosure protections under state and federal law.)

**If someone signs for me.** If a personal representative, parent, or guardian signs this form for me (Section 8), the practice may require proof of that person's legal authority — such as a power of attorney, a guardianship or conservatorship order, or a birth certificate for a minor — before releasing my records.

**Minors and self-consented care.** Under California law, certain minors may lawfully consent to their own care — for example, mental health treatment (Family Code §6924), substance-use/drug treatment (Family Code §6929), and HIV testing. **For records of care a minor lawfully consented to on their own, the minor — not the parent or guardian — must sign this authorization, and a parent or guardian generally may not authorize release of those records.** If this applies, ask us before completing the form.

**Copy.** I am entitled to a copy of this signed authorization.

---

## 8. Signature

*California notice (CMIA, Civil Code §56.11): This authorization is set apart from any other language on this page, and the signature below serves no other purpose than to execute this authorization. (See the production note at the top of this form: the rendered form must be in a typeface no smaller than 14-point.)*

I have read and understand this authorization. I am signing it voluntarily.

**This form is signed by the patient OR, if the patient cannot sign, by the patient's personal representative, parent, or guardian.** If you are signing as someone other than the patient, complete the "Authority to act" line below.

| | |
|---|---|
| Signature: | _____ |
| Name (print): | _____ |
| Date: | __ / _ / _ |
| I am signing as (check one): | ☐ The patient ☐ The patient's personal representative / parent / guardian |
| If not the patient — my authority to act (describe): | _____ |
| (e.g., parent, legal guardian, conservator, agent under a health care power of attorney) | |

*(Reminder: if you are signing for a minor, please first read "Minors and self-consented care" in Section 7. The practice may require proof of your legal authority before releasing records.)*

---

---

### Office Use Only — Administrative (not part of the patient's authorization)

*This section is for practice use and is separate from the authorization above. Complete this page after the patient has signed.*

| | |
|---|---|
| Received by: | ____ ***Date:*** **/ /** ___ |
| Patient identity verified: | ☐ Yes ☐ No Method: ___ |
| Representative authority verified (if applicable): | ☐ Yes ☐ No ☐ N/A Document seen: ___ |
| Copy given to patient: | ☐ Yes ☐ No |
| Filed in chart by: | ____ ***Date:*** **/ /** ___ |